Pounds (GBP). Cost of improved preservation technique was not included in the model. **RESULTS:** IPTx may generate 4.18 and 1.19 QALY gain vs MM and CPTx respectively by increasing heart transplantation rates and reducing the impact of CIT. Treatment costs are reduced by 4476 GBP vs MM and increased by 5768 GBP vs CPTx. **CONCLUSION:** Many patients die on the waiting list due to the lack of transportability of hearts from eligible donors. Improved preservation of explanted hearts may generate 58′496 GBP of economic value per each heart transplantation.

PCV19

A MODEL-BASED ANALYSIS OF THE EFFECTS OF INTENSIFYING LIPID-ALTERING THERAPY ON DIRECT MEDICAL COSTS OF CORONARY HEART DISEASE EVENTS IN A SECONDARY PREVENTION POPULATION IN THE UNITED STATES

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OBJECTIVES: To assess the effects of various lipid-modifying strategies on direct medical costs of coronary heart disease (CHD) events among a representative patient cohort with established CHD. **METHODS:** Model-based analysis, using data from clinical trials, published literature, and national databases to project CHD medical costs (emergency, inpatient, and outpatient) over 5 years. The analysis focused on hypothetical cohorts of 10,000 CHD patients (50 years of age or older) with any abnormal lipid parameter (LDL-C, HDL-C, Non-HDL-C, and/or TG). The expected number of CHD events was calculated using the Framingham Heart Study equation for secondary prevention. Age, sex, and coronary risk-factor data for patients with CHD were obtained from a nationally-representative US health survey. Direct medical costs were expressed in $US 2006, discounted annually at 3%. The drugs of interest included simvastatin (S) alone and fixed-dose extended release niacin/simvastatin (ERN/S), allowing an evaluation of increasing doses of S or adding a second agent to S. **RESULTS:** Direct medical costs of CHD events over 5 years are estimated to be approximately $3436 per patient for patients treated with 20 mg of S. These costs would decrease by 8.8% with 1000/20 mg of ERN/S. Compared to more aggressive lipid therapy with 40 mg of S, 1000/40 mg of ERN/S would decrease CHD costs by 9.1%. Relative to a maximum dose of 80 mg of S, the maximum dose of ERN/S (2000/40 mg) would reduce CHD event costs by 11.2%. **CONCLUSION:** Intensifying lipid-modifying therapy with fixed-dose ERN/S combinations would further reduce direct medical costs of CHD events more effectively than S monotherapy in a secondary prevention population. Further research on the cost-effectiveness of intensifying dyslipidemia treatment is warranted.

PCV20

EVALUATING GENDER DIFFERENCES IN HEALTH CARE RESOURCE USE AND OUTCOMES AMONG ELDERLY PATIENTS WITH CONGESTIVE HEART FAILURE

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OBJECTIVES: Examine gender differences in resource use, expenditures and mortality among U.S. Medicare patients following discharge from a hospital admission for congestive heart failure (CHF). **METHODS:** Analyses were conducted on national 5% sample of Medicare claims from January 1999 to December 2001. A cohort that had an initial hospitalization with a primary diagnosis of CHF was identified. Resource use at one year preceding and following the initial CHF admission was compared among males and females. Separate multivariate regression models were developed by gender to assess the factors associated with outcomes. Models included variables for patient characteristics, comorbidity, compliance with routine care and resource use in the year prior to CHF admission. **RESULTS:** A majority of the 34,540 CHF patients were white (86%), one-half were 80 years or older and approximately 58% were female. Male CHF patients had a higher Charlson comorbidity score compared to females (4.27 vs. 3.99; $p < 0.0001$). Females were more likely than males to have an inpatient readmission within 365 days (58.6% vs. 41.2%; $p = 0.016$), an emergency department visit within 180 days preceding (58.3% vs. 41.7%; $p = 0.0019$) and following CHF admission (57.7% vs. 42.3%; $p = 0.035$), physician office visits within 365 days preceding (58.5% vs. 41.5%; $p = 0.0001$) and following CHF admission (57.7% vs. 42.3%; $p = 0.0001$). Females were also more likely than males to die within 60 days (56.3% vs. 43.7%; $p = 0.009$), 90 days (56.5% vs. 43.5%; $p = 0.006$), 180 days (56.2% vs. 43.8%; $p = 0.0001$) and 365 days (56.1% vs. 43.9%; $p < 0.0001$) of the initial CHF admission. In multivariate models, factors associated with health care resource use, expenditures and mortality had similar trends in both gender models. **CONCLUSION:** There appears to be gender differences in resource use and outcomes among CHF patients. Effort to better target interventions, diagnostic and therapeutic, among patients at higher risk of adverse outcomes carries potential for cost-effective management of CHF patients.

PCV21

COST-EFFECTIVENESS OF HYPERTENSION TREATMENT IN GREECE: THE ECON-APROS STUDY

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OBJECTIVES: Determine hypertension-related costs and cost-effectiveness ratios of pharmaceutical treatment for patients with hypertension in Greece **METHODS:** Data was derived from the PharmacoECOnomic Assessment of Prognostic Risk Occupational Survey (ECON-APROS), a cross-country prospective study. The sample included individuals 30–75 yrs old, diagnosed with hypertension (Systolic Blood Pressure >140 mmHg and/or Diastolic Blood Pressure >90 mmHg), who were treated and monitored for a period of 1 year after the diagnosis. Patients were separated in two subgroups: a) those with uncomplicated hypertension (N = 1243) and b) those with complications e.g. CVD, CHD, MI etc. (N = 122). Demographic, clinical and socio-economic information was collected. Cost analysis was based on the direct cost estimations and the measurement of the effectiveness was based on the absolute reductions in the mean SBP for each subgroup after 1 year of treatment. The perspective of the Greek NHS was taken. Tariffs are referred to 2006 prices and costs are expressed in Euros. **RESULTS:** Mean direct cost per patient suffering from uncomplicated hypertension was estimated at 687€ per year while for the second subgroup was significantly higher at 1771€ per year. Mean reduction in the patients' Systolic Blood Pressure was 32.58 mmHg for the first subgroup and 34.38 mmHg for the second. Cost-effectiveness ratios for each subgroup were estimated at 21.1€/mmHg and 51.7€/mmHg, respectively, for every 1 mmHg lowering of the Systolic Blood Pressure. **CONCLUSION:** The long term consequences of untreated hypertension are both life-threatening, for